Knee + Foot + Ankle
SURGEON

13/11/2023

Professor Ron Paterson
Independent Reviewer
podiatricsurgeryreview@ahpra.gov.au

Dear Professor Paterson,

As President of the Australian Orthopaedic Foot and Ankle Society, I send to you along with this document a submission to the Independent review of the regulation of podiatric surgery.

There is an attached submission and also referred documents to accompany the submission.

I commend and thank you and the Podiatry Board for undertaking this necessary review.

Yours sincerely,

[redacted]

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Orthopaedic Surgeon
President Australian Orthopaedic Foot and Ankle Society

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AOFAS SUBMISSION

Independent review of the regulation of podiatric surgery

Thursday 16th November 2023

Introduction

On behalf of the Australian Orthopaedic Foot and Ankle Society (AOFAS), I make the following submission to the *Independent review of the regulation of podiatric surgery*. AOFAS is a subspecialty group of the Australian Orthopaedic Association dedicated to managing disorders of the foot and ankle.

Podiatric surgical training and the regulation of podiatric surgery in Australia has placed the general public at risk and we welcome the opportunity to respond to the current investigation into the high number of notifications regarding podiatric surgery. We commend the bravery of the current Podiatry Board to investigate years of poor outcomes and misleading of the general public by “Podiatric Surgeons”.

We wish the reviewer to be aware that “Podiatric Surgeons” are the only group of individuals who operate on the Australian public who do not have their training accredited, inspected and audited by the Australian Medical Council (AMC). The experiment of allowing a group to self-regulate and self-define their educational requirements requires close scrutiny which has so far been lacking, and we believe that this review is long overdue in the interests of public safety.

In response to the questions in the consultation document AOFAS would provide the following:

1.Do you think the way podiatric surgeons are currently regulated in Australia ensures consumers are well informed and receive appropriate care from podiatric surgeons who are suitably trained and qualified to practise in a safe, competent and ethical manner?

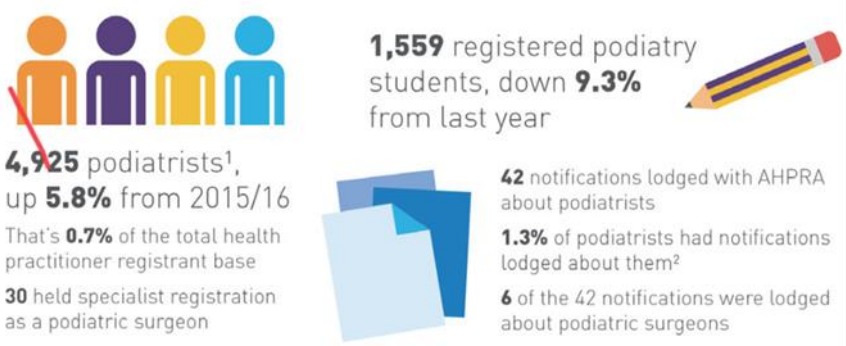
Current regulation of podiatric surgery in Australia is not conducted in a manner conducive to producing safe, competent and ethical “Podiatric Surgeons”.

Whilst we commend the current Podiatry Board on this review, we believe that this consultation may underestimate the notification rates and thus are concerned about current regulatory processes. We note that the Consultation Paper for this submission states “Podiatric Surgeons” receive an 8 times higher rate of notifications compared to general podiatrists. However, this is an underestimate of current and past notification rates. As per information published by the Podiatry Board presented below, historically there have been very high rates of notifications for “Podiatric Surgeons” in comparison to podiatrists with general registration.

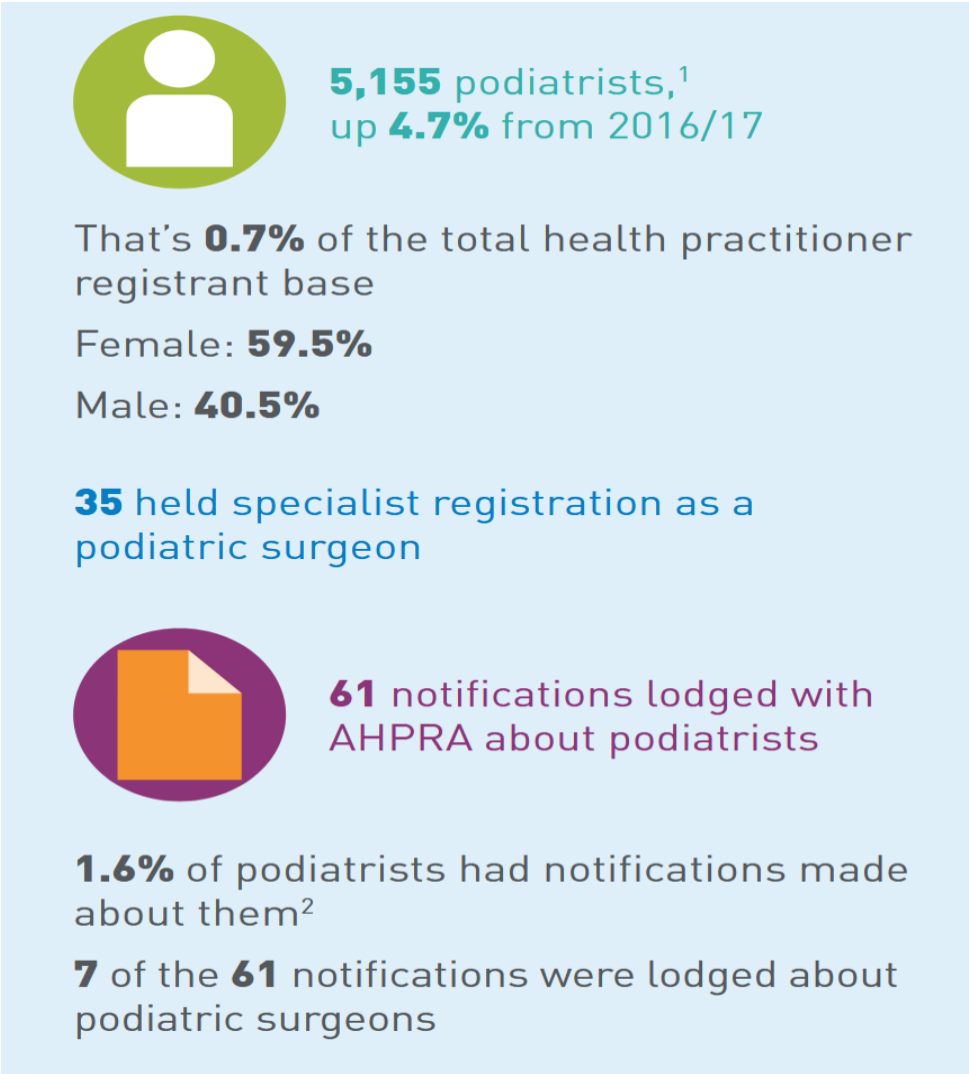
Podiatric surgery notification rates

The 2016/2017 “At A Glance” report published by the then Podiatry Board of Australia (PBA) states that there were 4925 podiatrists in the country, of which 30 were “Podiatric Surgeons”. In this year, there were 42 notifications to the Podiatry Board and 6 of these were related to “Podiatric Surgeons”. Thus there were 36 notifications regarding general podiatrists of which there were 4895. This results in a notification rate for general podiatrists of 0.7%. In addition, as there are only 30 Podiatric Surgeons, 6 notifications represents a notification rate of 20% for this group of operating podiatrists.

Thus, a “Podiatric Surgeon” is over 28 times more likely to receive a notification than a general podiatrist. This is much greater than the stated 8 times in the consultation documents.



The 2017/2018 report shows there were 61 notifications for all podiatrists, of which there were 5155. The number of "Podiatric Surgeons" increased to 35. There were 7 notifications about a "Podiatric Surgeon". This reflects a 1% (54/5120) notification rate for podiatrists with general registration, and a 20% notification rate for podiatrists registered as a "Podiatric Surgeon".



In addition, it needs to be recognised that notifications to the PBA may only represent a proportion of adverse events from all practitioners. Legal proceedings from a patient who sustained a poor outcome may not necessarily result in a complaint to AHPRA. This lack of reporting of litigious events should be considered by the reviewer. Whilst compulsory

notifications occur if a practitioner is deemed financially fraudulent, we simply do not know if the results of legal proceedings are passed on to regulatory bodies.

The 2017/2018 report shows there were 61 notifications for all podiatrists, of which there were 5155. The number of “Podiatric Surgeons” increased to 35. There were 7 notifications about a “Podiatric Surgeon”. This reflects a 1% (54/5120) notification rate for podiatrists with general registration, and a 20% notification rate for podiatrists registered as a “Podiatric Surgeon”. Again, this demonstrates the notification rate for a “Podiatric Surgeon” is 20 times higher than a podiatrist with general registration.

We question why the 2018 PBA then changed their communication strategy, to disclosing notifications specific to “Podiatric Surgeons” hidden in the body of a lengthy report, rather than in the more easily readable ‘At A Glance’ publications. Data after this time is not freely available and there was no explanation by the 2018 Podiatry Board as to why AHPRA changed their reporting style to make this information more difficult to access.

We question the current regulatory process that fails to report notification rates known for “Podiatric Surgeons”, meaning the general public are unable to access this data and make an informed choice about the practitioner providing their care.

Underreporting to AHPRA

The current national health regulation law across a number of states relies on dual regulation. In Queensland, the Office of the Health Ombudsman receives notifications about registered health practitioners. In NSW the Health Professional Councils Authority and the Health Care Complaints Commission performs this function. In the past, authorities in one jurisdiction may be unaware of complaints currently under investigation elsewhere and notifications about a dangerous “Podiatric Surgeon” may not be detected. We welcome recent changes that have allowed for automatic notification to AHPRA in some states, but are concerned this still may result in unnecessary delays for decision-making about practitioner’s conduct and practice and subsequently put more patients at risk of harm. In addition, the duration of prolonged notification in a dual regulated setting puts the practitioner in question under further stress which may result in even poorer outcomes for both the practitioner and the patients they are treating.

Many “Podiatric Surgeons” practise across several states as stated on the Australasian College of Podiatric Surgery (ACPS) website (for example, [redacted], [redacted], [redacted] and [redacted]) which means that notifications may not be communicated to AHPRA at all and serial notifications may not be identified if these occur in separate states. This dual regulatory process reflects limitations in current regulatory practice and exposes the general public to a “Podiatric Surgeon” who may have had a serious adverse event currently investigated in one state, but AHPRA is unaware of this issue as the investigation is with the local state regulatory body. We recommend that it be mandated that AHPRA be advised of all notifications regarding “Podiatric Surgeons” and have the ability to inform the Queensland and NSW authorities of all known current investigations and notifications.

In addition, it needs to be recognised that notifications to the PBA may only represent a proportion of adverse events from all practitioners. Legal proceedings from a patient who sustained a poor outcome may not necessarily result in a complaint to AHPRA. This lack of reporting of litigious events should be considered by the reviewer. Whilst compulsory notifications occur if a practitioner is deemed financially fraudulent, we simply do not know if the results of legal proceedings are passed on to regulatory bodies.

Attached is a letter ([redacted] from [redacted] [redacted] [redacted] a successful QLD private injuries firm, who advises that he never suggests to his clients that they formally notify PBA of the event being litigated. This is because it has been his experience

that past PBA complaints and notifications have resulted in limited benefit for the client, who is already undertaking an already stressful legal interaction.

As a result, there are a number of patients with serious adverse events who choose not to notify the Podiatry Board. We would be confident therefore, that the PBA is unaware of the true extent and number of adverse events which result from operations performed by “Podiatric Surgeons”.

2. Do you have any suggestions to improve the current system for regulating podiatric surgeons?

We have two suggestions to improve the current system for the regulation of “Podiatric Surgeons”.

First and foremost, we believe that the title “Surgeon” should only be used by and awarded to practitioners who have undergone an Australian Medical Council (AMC) accredited surgical training program. This would help address public misconception of the term “Surgeon” which currently can reflect the qualifications of both a medical practitioner who has completed a medical degree and subsequent specialist orthopaedic surgical training, and a podiatrist who has completed a podiatry degree and podiatric surgical training, which is not of the same standard as orthopaedic surgical training (discussed further in this document).

Secondly, we support regulation of a predefined standard of practice for “Podiatric Surgeons”. This would address the multiple podiatric surgery training pathways in Australia resulting in multiple training bodies and training standards. The acceptance of these bodies’ standards without referencing against an independently defined International or AMC certified standard has resulted in variable training standards and may be contributing to the high number of notifications and unacceptable outcomes of podiatric surgeons.

Title Protection

AHPRA and the reviewer would be aware that the issue of the use of the term “Surgeon” is currently extremely contentious. This was a direct result of the National Registration Legislation (NRL) passed in 2010. Prior to this, the term “Surgeon” was protected in most jurisdictions, and assurances were secured by the Australian Orthopaedic Association (AOA), and Royal Australasian College of Surgeons (RACS) that there would be the persistence of this practice in the National Registration Legislation.

However, the government at the time changed the legislation to protect the term “Orthopaedic surgeon” or “Neurosurgeon”, rather than the generic title “Surgeon”. Accordingly, individuals who were performing cosmetic procedures were able to use the term “cosmetic surgeon” and as a consequence of this, patients were incorrectly of the opinion that those individuals were specialist trained plastic and reconstructive surgeons. Severe damage was done to patients because persons with inadequate training were allowed to access and use the term “surgeon”, and patients assumed their surgeon underwent the same rigorous training and regulation as a plastic and reconstructive surgeon where in actual fact, the title did not reflect appropriate training standards.

The Federal Government has recently passed legislation which prohibits the use of the term “surgeon” by medical practitioners to those medical practitioners who have undergone an AMC accredited training program. As such, and allied health professional is still free to use this term. We believe that in the interests of public safety, this should be extended to allied health professionals who do not have a medical degree yet can still, under current legislation, use the title “surgeon”.

A Galaxy poll [redacted] conducted by the AOA, demonstrated that over 93% of people who were polled thought that use of the term "Surgeon" should be by a specialist medical practitioner with specific advanced training in surgery. The use of the term "Podiatric Surgeon" is therefore extremely misleading and implies that the training, competency and ethical standards of a "Podiatric Surgeon" are the same as the rigorous, highly regulated standards of a medically and surgically trained orthopaedic surgeons.

Our association's members regularly see patients who have had poor outcomes associated with podiatric surgery. It is the experience of many members of the Australian Orthopaedic Foot and Ankle Society (AOFAS) who manage podiatric surgery complications, that these patients are taken aback to learn that the individual portraying themselves as a "Surgeon" is neither medically trained, or a surgeon in their common understanding of the word.

We are also concerned that the conferral of the term "Podiatric Surgeon" was not undertaken because podiatric surgeons demonstrated a level of training commensurate with AMC certified training of orthopaedic surgeons, or had achieved an AMC standard education. The term was offered solely to differentiate "Podiatric Surgeons" from podiatrists with general registration and separate them from the rest of their profession.

As such, we believe that the public would be best served if the Protected Title "Podiatric Surgeon" was removed and the term "Surgeon" utilised only for practitioners who have undergone AMC accredited surgical training. We support the use of the titles "Paediatric Credentialed Podiatrist" and "Sports Credentialed Podiatrist" which offer the general public insight into further qualifications and training of their treating practitioner, but still demonstrates the practitioner is a Podiatrist. We would recommend the use of "Operative Podiatrist" or "Operative Credentialed Podiatrist" instead of the term "Podiatric Surgeon", which would reflect similar additional training received by other subspecialty podiatrists but still informs the patient that their practitioner is a podiatrist, as distinct from a practitioner who has gone through an AMC accredited surgical training program. Patients would then be able to make an informed choice and avoid confusion with the term "Surgeon"

The continued use of the term "Podiatric Surgeon" represents an ongoing risk to patients. The general public has difficulty differentiating between a "Podiatric Surgeon" and a medically trained orthopaedic surgeon despite the vastly different training pathways and experience, often, sadly to the detriment of their own safety.

Adherence to a Predefined Training Standard

We are concerned that there are currently two different providers of training to "Podiatric Surgeons" in Australia, and in the future there may be even more. Rather than accepting multiple different training pathways and standards, we suggest an acceptance of an AMC certified standard, and then to test the current and prospective podiatric surgery training programs against these predefined standards.

We believe that the standards that currently exist are fundamentally inadequate (see answer to Question 3) as they simply were an acceptance of the existing practitioners on the register, and not an adoption of an independent standard. The multiple methods by which "Podiatric Surgeons" are trained in Australia reflects the poor adherence to a regulated education process and is not a reflection of the standard of international training in Podiatric Surgery.

The current training programs for "Podiatric Surgeons" have never met the standards required for accreditation internationally by the CPME or in Australia by the AMC and as such should not be endorsed by PBA until they do.

3. Do you have any concerns about the registration requirements for podiatric surgeons? Are changes needed and why?

There are very real concerns regarding the way the registration requirements for "Podiatric Surgeons" were formulated and implemented. Historically, members of the PBA have been supportive of "Podiatric Surgeons". Without having audited or inspected the groups, the 2010 PBA supported the expansion of the scope of practice of Podiatry to include the formation of a specialist register of podiatric surgery without any evidence to demonstrate that the Australian training program produced safe, competent and ethical "Podiatric Surgeons". We elaborate on this issue below:

International Recognition

North American data on podiatric surgery outcomes is not applicable to Australia. The reviewer should therefore be aware that no Australian podiatrist can be registered in the United States based upon their Australian qualifications. No "Podiatric Surgeon" in Australia can, with their Australian qualifications, operate in the United States unless they have been completely retrained. Australian trained Podiatric surgeons are not even able to work as general podiatrists in North America.

"Podiatric Surgeons" and even general podiatrists in Australia do not undergo the same training as their North American counterparts. In the United States, all applicants to Podiatry undergo an exam called the Medical College Admission Test (MCAT). This is an exhaustive examination on all basic sciences and anatomy. It is an entrance examination used as a selection tool (in addition to other selection tools) for potential students wishing to study health care, including the fields of medicine, osteopathy, chiropractic and podiatry. A "Podiatric Surgeon", trained in the United States, but with Australian origins, advises that it took two years of studies to prepare for the MCAT examination.

To work as a surgeon in the United States, an Australian trained "Podiatric Surgeon", would need to successfully pass the MCAT exam, completely redo their undergraduate podiatry degree, work as a podiatrist, become accepted into a recognised training programme for podiatric surgery, complete that programme and its examinations and become board certified to practice in the United States. American Podiatric Surgery training is a four-year hospital based residency program, similar to that required for Orthopaedic Surgery. Thus, outcomes of surgical interventions performed by American surgical podiatrists are superior to and not comparable with the outcomes of so-called Australian "Podiatric Surgeons" who undergo a vastly different training process.

Members of the ACPS have suggested they are recognised by the American College of Foot and Ankle Surgeons (ACFAS). We have written to the ACFAS ([redacted] who have replied that "ACFAS International Affiliate Status does not in any way endorse or designate competency of the physician", it merely provides a method by which they can access ACFAS services such as literature or attending American meetings.

Canada similarly has strict regulations on the use of the term "Podiatric Surgeon" and an Australian "Podiatric Surgeon" cannot practice in its jurisdictions ([redacted]

Granting of Protected Title

We recognise that the regulation process for "Podiatric Surgeons" included in 2010 an application put before the Australian Health Workforce Ministers Council (AHWMC) to have access to the restricted title "Podiatric Surgeon" and to allow the creation of the Specialist Register for Podiatric Surgery.

This was enabled by a submission to the ministers of a review of "Podiatric Surgeon" training: "Podiatry Specialisation Education and Training Accreditation Standards Project" performed under the auspices of the Australian and New Zealand Podiatry Accreditation Council

(ANZPAC) (We recognise that ANZPAC has since been disbanded by the current podiatry board, but they performed a vital role in 2010.

We would like to highlight that several members of this committee were "Podiatric Surgeons", but this was not apparent in the general public documents. were all podiatric surgeons at the time the committee was formed (see below). In addition, and were in a marital relationship suggesting some conflict of interest between the executive committee and the accreditation committee (

Board of Management

Executive Committee

The Council wishes to express its sincere appreciation and thanks to

Accreditation Committee (AC)

The author of the paper was neither a medical practitioner, orthopaedic surgeon, or a podiatrist. It was authored by an individual who was present as a community member We would like to highlight that the author of this paper had no Medical, Podiatric (or Surgical training, yet defined for ANZPAC and the PBA the Educational Requirements needed to practice Surgery on the Australian Public. This reviewer recommended acceptance of the ACPS standard of training as suitable to be endorsed. Unlike this current review, there was no public consultation. The previous review did not make contact with Royal Australasian College of Surgeons, the peak body for surgery in Australia nor was there any contact with the AMC (who certify surgical training in Australia) or the CPME (who certify surgical training of podiatrists internationally).

there was much controversy over the same issues that we enunciate here regarding the creation of a standard by members of ANZPAC, some of whom strongly felt the entire process rushed and poorly performed. Of some concern, this study was jointly funded by the Victorian Podiatry Board (whose President at the time, was also a "Podiatric Surgeon" (suggesting significant ethical and financial conflict of interest. was also on the Accreditation Committee of ANZPAC (and actively petitioned for acceptance of the report.

In what can only be described as a process deeply lacking in objectivity and independence, the report was accepted and passed to the 2010 Podiatry Board of Australia, with receiving the report as a member of the 2010 PBA (a study he had funded

([redacted] and which would advance the group of “Podiatric Surgeons” that he was the President of ([redacted]

This review process was ultimately flawed in that it did not acknowledge the international standard of the CPME, nor AMC accreditation standards, a standard which had previously been committed to in the lead up process of National Registration Legislation ([redacted]) regarding the formation of new specialist groups in Podiatry.

The 2010, the PBA submitted to the AHWMC an application to recognise a specialty called “Podiatric Surgery” and create a restricted title “Podiatric Surgeon”. Under the agreements leading up to the National Registration Legislation there was an obligation to advise AHWMC and the Health Ministers of the contrary views ([redacted] of the Australian Medical Association (AMA), the AOA, the Australian Orthopaedic Foot and Ankle Society (AOFAS) and the RACS, but there is no evidence that this occurred.

It is also troubling that whilst this application to AHWMC proceeded, with the illusion of a standard having been defined to allow individuals to operate on the public in Australia and use the term “Surgeon”, the PBA would not publish a Standard of Training for Podiatric Surgery for half a decade ([redacted] and this standard only came into effect on 24 February 2015, and no inspections were made by the Accrediting body for some time.

Without published, publicly available audits of surgical outcomes performed by “Podiatric Surgeons”, the 2010 PBA advocated to the AHWMC for creation of a specialist register of individuals whose academic and educational credentials it did not know, and allowed the use of the title of “Surgeon” to individuals whose standards they neither understood or had investigated. We are concerned about the regulatory processes of the Podiatry Board at the time, and the subsequent ramifications and high notification rates of “Podiatric Surgeons” that occurs now.

There are Podiatric Surgeons working today who have never had their training inspected or independently audited or verified. In spite of this, these individuals were permitted to use the term “Podiatric Surgeon” and be registered on this specialist register, despite the fact that the Podiatry Board at the time had not and has never actually created a specialist standard.

We also present our concerns over the ease by which the ACPS obtained recognition by the state Podiatry boards. In 1996, the ACPS approached the Podiatrists Board of Queensland to request recognition and access to operate on the public in Queensland. [redacted] the ramifications of the ease with which “Podiatric Surgeons” were endorsed, has led to patient harm stemming directly from questionable ethical, professional and technical standards of its members.

The Podiatry Board of Queensland appears to have sought the advice of only a single individual as to what was the appropriate standard of care that should be adopted for “Podiatric Surgery” within the state of Queensland. In the report, the speaker stated that he felt the ACPS was the accepted surgical group and that the Podiatrists Board of Queensland should recognise the qualifications of the fellowship of the ACPS as the standard for practising “podiatric surgery” in Queensland. On that same day, without any further information, deliberation, or consultation with any recognised surgical entities, the Podiatrists Board of Queensland created and carried a policy to define the ACPS as the training standard for the conduct of “podiatric surgery” in Queensland. The individual who presented this matter to the board at the time was a podiatric surgical registrar ([redacted] and as such a trainee member of the ACPS, who was advocating for the standard of training he was currently

undergoing, to be accepted. This conflict of interest was not mentioned in the minutes of the meeting.

It does not appear that the 2010 PBA undertook any more rigorous investigation of the claims of the ACPS, and nor did ANZPAC investigate and exercise appropriate due diligence to ensure the safety of the Australian public despite that being the chartered duty of the PBA. As a result of the relative ease of granting of titles and specialty status, and in the face of poor evidence as to whether "Podiatric Surgery" in Australia is safe, there is now a large increase in notifications from "Podiatric Surgery" in Australia.

We are aware that there is a high number of "podiatric surgeons" who have restrictions placed on their practice. A review of the AHPRA register of practitioners has demonstrated that five out of 32 podiatric surgeons who are fellows of the ACPS currently have their practice restricted ([redacted], [redacted], [redacted], [redacted] and [redacted]). Currently, 15.6% of "Podiatric Surgeons" who are active fellows of the ACPS, the very organisation that states on their website that its primary objective "is to advance knowledge in podiatric surgery and uphold the highest standards of foot and ankle care provided by podiatric surgeons to patients and the community" are under supervised and/or restricted practice despite being granted their fellowship in podiatric surgery. This further suggests in concrete terms, that "Podiatric Surgeons" in Australia are not suitably trained and qualified, and are not currently practicing in a safe, competent and ethical manner.

4. Do Podiatry Board's current standards, codes and guidelines help ensure podiatric surgeons perform podiatric surgery safely?

The PBA's current standards are not adequate as they are not founded on International Standards, nor Australian AMC accredited standards. Whilst there have been some improvements, we are concerned that "podiatric surgery" training in Australia does not meet AMC accreditation standards, nor international standards.

Training standards

Appended below a copy of every training program published by the ACPS that is publicly available ([redacted]).

Every single one requires that all candidates have achieved a Masters degree prior to sitting their podiatric surgery exams. Several senior members of the ACPS, including [redacted] and [redacted], do not hold a Masters degree. These individuals should never have been permitted to sit their exams yet are not only practising but involved in the teaching and training of "podiatric surgeons". According to the AHRPA register of practitioners, [redacted] most advanced qualification is a Diploma of Applied Science. Despite this lack of tertiary qualification, [redacted] is still able to teach podiatric surgical trainees who require a minimum Masters level qualification to complete the program. We question why the qualifications of the teacher are far inferior to the practitioner they are teaching, and do not meet the expected standard of tertiary education that has been set by their own training college.

Prescribing endorsement for "podiatric surgery" is now compulsory, but a review of AHPRA registration demonstrates that at least five "podiatric surgeons" registered with ACPS ([redacted], [redacted], [redacted], [redacted] and [redacted]) continue to practice without prescribing endorsement. We question how these practitioners are prescribing pain relief for their patients, or antibiotics in the setting of post-operative infection. AHPRA continues to support the registration of these "podiatric surgeons" who do not have prescribing endorsement despite contradicting their own standards of training and practice.

It is highly unlikely a member of the general public undergoing a procedure with a "podiatric surgeon" without prescribing endorsement would be aware that their treating practitioner is not permitted to prescribe pain relief or antibiotics, and that the patient would have to seek the care of their General Practitioner or Emergency Department if they had an unexpected problem after surgery. This results in further unnecessary cost and time to patients for medical doctors who subsequently manage what is routine post-operative care for a medically trained orthopaedic surgeon.

We also express concern about the prescribing endorsement training. In submission to the Queensland Health requesting the right to prescribe, the ACPS stated that their Fellows undertook tertiary education in pharmacology via a specified course at Curtin University. Communication was then made to Dr [redacted], the individual who ran the Pharmacology course, and he advised the course itself did not provide the educational basis equivalent to Medical Students, and that the education in itself was not enough to prescribe ([redacted]).

Only six "Podiatric Surgeons" had completed this course ([redacted]). At the time, there were 20 "Podiatric Surgeons" in Australia, so less than one third of registered "podiatric surgeons" at the time had actually completed the course. We recognise that the current Podiatry Board does not endorse this course, and it does not meet current standards for endorsement of scheduled medicines for podiatrists, but this course may have resulted in poorly trained "Podiatric Surgeons" who do not understand the medications they may be prescribing.

Training of surgeons

We have grave public safety concerns stemming from the current training program of "Podiatric Surgeons" and its regulation in Australia. We would point to the Training Program Number 3 ([redacted]), in which the ACPS states to it's potential registrars that the ACPS is responsible only for the assessment of Registrars, "and provides guidance and structure in respect of practical training. No guarantee is provided by the ACPS that practical training will be provided". This is a concerning admission from the body which claims to be the peak training model for "Podiatric Surgery", which admits that it does not teach those enrolled in its training program the practical techniques of surgery.

Patient consent

We are also extremely concerned that this training, if it does occur, is being performed on patients who may not be aware they are subject to a trainee potentially performing their surgery. We are disturbed deeply that patients who are paying a private surgeon to perform a procedure may have someone other than their treating "podiatric surgeon" perform their surgery. We question whether patients are fully consented to a trainee performing their procedure and are aware of the experience, limitations and knowledge of the trainee.

We contrast this experience to public hospitals. Orthopaedic surgical trainees are constantly supervised, and there are regular, extensive, multidisciplinary, peer-reviewed clinical audits and all orthopaedic registrars have multiple surgical supervisors. Clinical competence and safety is constantly reviewed in the public system, and patients undergoing treatment through the public system are aware of the training programs and level of training of their treating doctor. This process is not replicated in the private system, where private patients have a different ethical and financial relationship with their practitioner, and all treatment is performed by the treating orthopaedic surgeon.

"I have specifically asked all the patients who I have seen as a second opinion if they consented to having someone other than the "podiatric surgeon" they saw operate on them, and not one has said that they signed or gave verbal consent to someone else performing their surgery" says [redacted] (Orthopaedic Foot and Ankle Surgeon, AOFAS member). "However, it is a requirement of the ACPS that procedures are actually performed

by the training podiatric surgeon. The issue of consent is extremely important. None of the PBA's Standards or codes address these issues, despite these issues having been presented to the PBA in previous submissions".

Private hospital day surgery centres

"Podiatric surgeons" commonly operate on patients either under local anaesthetic in their rooms or in small day surgery centres. Day surgery centres are often smaller with limited medical cover in the event of an emergency. We question whether these day surgery centres are aware that some "podiatric surgeons" have obtained registration in their centres without prescribing endorsement (as mentioned, 12.5% of current ACPS fellows do not have prescribing endorsement). Subsequently, patients may be admitted to a small day hospital for an invasive surgical procedure where no one is available to prescribe pain relief, resuscitate and stabilise the patient or arrange transfer to a larger facility if required.

We question whether these day surgery centres have appropriate insurance to cover an allied health practitioner performing surgical procedures on admitted patients, when the allied health practitioner is unable to stabilise and transfer a patient to a larger centre if required. Many day surgical centres, due to their small size, will not have a formal Medical Advisory Committee (MAC), whose duties include inspecting the credentials of people seeking admitting rights to the centre.

Day surgery centres do not have a rigorous audit process like larger private hospitals with a high dependency or intensive care unit, emergency department and multidisciplinary teams. Private hospitals in Melbourne – who do not register "podiatric surgeons" – include Cabrini Malvern, Epworth Richmond and Peninsula Private. All these centres have six monthly morbidity and mortality audits where complications such as re-admissions, delay in discharge and thromboembolism are identified and surgeons are required to present their morbidity and mortality audit to the entire surgical department. It is unlikely smaller day surgery centres will capture this data, nor run rigorous, peer reviewed audits to prevent further complications and identify areas of improvement.

Full Time Training

There is a declaration that the Podiatric Registrars are "full time registrars", but this cannot be the case and is certainly not the equivalent of 'full time training' undertaken by medically trained surgical registrars working in the public hospital system.

Podiatric surgical trainees are supposedly "full time", but practically speaking, they are simultaneously completing a full time Masters degree, working as a general podiatrist (and referring patients to their supervising podiatric surgeons) and completing their requirements for "full time" podiatric surgery training. This is simply not feasible or possible. Podiatric surgery training takes an average of four years to complete. This "full time" podiatric surgery training, combined with a full time Masters degree, and working as a general podiatrist cannot physically be completed simultaneously. Of note, podiatric surgical trainees are not employed by their supervisors or training body, and are necessarily funding their training via general podiatry practice which is already a full time job.

Overall, the outcomes of the notifications and suspensions publicly available would show that the Training Program and whatever practical surgical training that the podiatric surgical trainees might receive is inadequate.

5. Do the current professional capabilities for podiatric surgeons appropriately describe the knowledge and skills required of podiatric surgeons for safe practice?

No.

In the lead up to the NRL, the 2010 Podiatry Board and ANZPAC gave an undertaking that any new Specialties that were defined would adhere to International Standards ([redacted] Were this to have occurred, then the CPME standard would have been adopted, and the providers of surgical training would have had their training programs tested against this pre-defined standard.

In an independent transparently administered system, there could be any number of providers of Surgical Training. Each of these would be measured against the predefined standard regularly, and if they achieved the standard then their trainees would be able to use the term "podiatric surgeon".

The 2010 PBA (see Question 3) allowed ANZPAC to have an independent reviewer approve a training program without reviewing the training program facilities and conduct of the program, nor attending the sites of the surgical training locally or internationally (to understand what World Best Practice is). Instead, it appeared that the status quo was acceptable.

Indeed, the original paper recommended a single pathway to becoming a "Podiatric Surgeon", (the ACPS training program), and the UWA training program was later included not because of a demonstration of high quality training, but a veiled threat to delay the passage of the report so that it could not be presented to the Health Ministers and the Specialty of Podiatric Surgery not be recognised before the implementation of the National Registration Legislation ([redacted]

6. Are any changes to the standards, codes and guidelines needed? If so, why? What additional areas should the standards, codes and guidelines address to ensure safe practice?

As stated above, we firmly believe that the only way integrity of training could ever be achieved within the Podiatric Surgical fraternity would be for the existence of a pre-defined standard of training, accepted by the AMC, that was rigorously applied to all the providers of surgical training.

No exemptions should be permitted, and no grandfathering in of individuals or organisations should be permitted. "Podiatric Surgeons" who are currently registered by AHPRA must demonstrate competency in a newly defined standard of training and practice to ensure standards, codes and guidelines to safe practice.

Absolute integrity is required to restore any degree of faith in the process by which "podiatric surgeons" are trained and permitted to operate.

There are a large number of "podiatric surgeons" who have had repeated restrictions placed on their practice. These restrictions are removed after a period of time, but then are put in place again in the event of another notification. Such practitioners include [redacted], [redacted], [redacted] and [redacted]. We question why these "podiatric surgeons" have repeated restrictions placed on their practice yet are still permitted to return to unrestricted practice as a "podiatric surgeon", only to have another notification and restrictions applied again. This cycle of restrictions, then ease of restrictions, and re-restriction suggests the same pattern of behaviour is occurring. We strongly recommend permanent restriction of practice for 'repeat offenders' to protect the public and prevent further patient harm.

7. Do you have any concerns about education and training for podiatric surgeons? Are any changes needed, and why?

There are significant concerns regarding the education and training of podiatric surgeons.

A review of the AHPRA register of practitioners has demonstrated that 5 out of 32 podiatric surgeons who are fellows of the ACPS currently have their practice restricted ([redacted], [redacted], [redacted], [redacted] and [redacted]). Therefore, at time of writing, 15.6% of podiatric surgeons who are active fellows of the ACPS, the very organisation that states on their website that its primary objective "is to advance knowledge in podiatric surgery and uphold the highest standards of foot and ankle care provided by podiatric surgeons to patients and the community" are under supervised and/or restricted practice despite being granted their fellowship in podiatric surgery. There are therefore glaring inadequacies in the current podiatric surgical training program and the general public deserve to receive treatment by a practitioner whose training does not determine that 15.6% of its graduates need to be supervised or have their practice restricted after their 'training'.

We are concerned that podiatric surgical training involves meeting with a mentor or supervisor only once per week, as recommended by the training guidelines ([redacted]). In this model, a podiatric surgical trainee is not exposed to surgical outpatients clinics where a consultant surgeon is present. For comparison, Orthopaedic surgical training requires orthopaedic registrars to be present in supervised outpatient clinics in a public hospital setting, a minimum of three sessions per week and includes constant supervised assessment, formulation of management plans and pathology and imaging reviews. Orthopaedic surgical trainees in a public hospital work constantly in a multidisciplinary environment and develop an understanding of the network that is required to provide patient centred care. It is unfathomable that a similar exposure would occur in a situation where the podiatric surgical trainees meet the mentor, or podiatric surgeon, about once a week as is the recommended contact time identified in Training Programme 3 ([redacted]

A medically trained orthopaedic registrar, having completed a medical degree, and between four and eight years of service jobs as a resident, junior house officer, senior house offer, and non-trainee surgeon (also known as an 'unaccredited registrar) would have daily contact with an orthopaedic surgeon, and every single clinic and operation is either discussed with the consultant surgeon, or supervised by them. After five years of full-time work as an Orthopaedic Trainee, and after completing a fellowship exam, an orthopaedic surgeon will undertake between one and three years of training gaining specific skills in Foot and Ankle surgery. Only after this additional training would an orthopaedic surgeon be recognised as a fellowship trained, Foot and Ankle Orthopaedic surgeon.

In all of this surgical experience, from a non-training registrar to consultant orthopaedic surgeon, the trainee is involved in the entire decision making process, surgical planning and operation and is intimately involved in the post-operative care and follow up, a process which is not replicated by the existing training programme for "podiatric surgeons".

Of further concern, podiatrists with general registration who are interested in "podiatric surgery" are encouraged to refer patients to "podiatric surgeons", thus generating a referral base for their "surgical trainers". The offer of 'mentorship' and 'supervision' by a "podiatric surgeon", and observation of surgeries required to complete training, is reliant on the podiatrist referral base. Post-surgery patients are then referred back to the original podiatrist for ongoing care which can include expensive orthotic treatment. This financial and ethical conflict of interest is not present in the surgical training of any health practitioner conducted in the public hospital system, where a referral base includes General Practitioners, Emergency Physicians and other specialist doctors who have no direct involvement in the supervision or assessment of orthopaedic trainees.

Procedures versus operations and limitations to operative experience

"Podiatric surgeons" have adopted the term 'procedure' rather than 'operation'. Podiatric surgical trainees are assessed on the number of procedures performed, defined as a single step in an operation. A single operation may have multiple "procedures". For example, a simple extensor tendon release of the 2nd, 3rd, and 4th toes performed under the same anaesthetic and at the same sitting, would be classified as one operation by an orthopaedic surgical trainee. An orthopaedic surgeon would also classify this as one operation. However, a podiatric surgical trainee would define this as three individual surgical "procedures", grossly inflating their experience and case "numbers". In this way, the small number of operations performed by "podiatric surgeons" and their registrars can be inflated to make it appear that the surgical experience of their podiatric surgery trainees is larger than it truly is.

The published data by the ACPS in 2016 ([redacted] indicates that 2080 procedures per year are performed by all "podiatric surgeons" in the country in total. This is spread over approximately 24 podiatric surgeons (taken from 2018 census of ACPS members Document 35). However, one third of these cases represent toenail surgery – considered very minor surgery - which can be performed by a podiatrist with general registration, and as such, not part of the exclusive domain of podiatric surgeons.

This means the surgical exposure of the entire cohort of "Podiatric Surgeons" for 2016 represents approximately 1456 cases between 24 Podiatric Surgeons. This means an average podiatric surgeon will do a total of 60 cases a year or about one procedure per week. In distinct contrast, a fellowship trained orthopaedic surgeon would easily perform 60 operations (not 'procedures') over a one month period, an orthopaedic surgical trainee would report 200-400 surgical operations (not 'bundling' of procedures) in a six month rotation.

The 2018 Data ([redacted]) states that 2306 cases were performed by the ACPS but 44% were toenail surgery (thus excluded). This means a total of 1219 cases shared amongst the 24 Australian based Podiatric Surgeons in the ACPS ([redacted]), yielding a total of 50 cases per year.

If four Podiatric Surgeon registrars are in training at one time, and they take four years to complete their training, then a registrar would have to be present at every single case performed by every "podiatric surgeon" in Australia to meet their required number of cases for training. This is logistically and geographically impossible and we question the reliance of data presented by the ACPS.

In addition, there is no mention of 'competency', or ability to safely perform these surgical procedures. We question whether these 'procedures' are performed to an appropriate standard. Without assessment of competency, the current podiatric surgical training program cannot (and – by the high rate of notifications – clearly is not) produce safe and competent surgeons.

We believe the current high notification rate for "podiatric surgeons" reflects a lack of operative exposure and inflation and exaggeration of operative experience to meet podiatric surgical training requirements at the expense of the public who are then treated by an inadequately trained "surgeon".

Clustering of Surgical Cases during surgical audits

In addition to 'unbundling' of operations, "podiatric surgeons" have reported procedures performed and have attempted to categorise these procedures, presumably for ease of reporting. However, "podiatric surgeons" have combined 'hindfoot arthrodesis' with 'ostectomies and osteotomies'. This equates the technical merit of performing an ankle fusion, which requires vast skill and attention to detail, followed by up to 12 months of follow-up and care, to the simple intervention of removing a prominent bit of subcutaneous bone. We question this reporting practice, which is vastly different from public hospital audits, individual orthopaedic surgeon audits and MBS coding practices.

Furthermore, the data on Table 1 of the ACPS "audit" ([redacted]) shows that less than 6% of cases performed by a "podiatric surgeon" are in the Hindfoot and Midfoot, and so the cumulative experience of the cohort with major Foot and Ankle Surgery is negligible.

With respect to the hindfoot surgery, the audit clumps together item numbers for ankle replacement, ankle stabilisation and Achilles surgery, and subtalar fusions and coalition releases with plantar fasciitis treatment. However, using the numbers from 2017 audit ([redacted]), the total hindfoot surgery cases – large and small - performed by the ACPS is 93 cases, by 24 active Australian members ([redacted]), (we have excluded the ACPS Active Overseas members) and this amounts to about 4 cases a year per surgeon. This caseload is wholly insufficient to maintain competency and train registrars. Most foot and ankle trained orthopaedic surgeons would do more cases than this in an average week.

This has not prevented many "podiatric surgeons" claiming that they are capable of performing major midfoot and hindfoot surgery. We make reference to the website of "podiatric surgeon" [redacted] who states he can perform midfoot arthritis surgery, metatarsal fracture repair, heel pain surgery, accessory bone removal and flat foot surgery.

There are numerous articles where outcomes of surgery have been shown to related to volume of surgical experience, and Chowdhury et al ([redacted]) conducted a systematic review of surgery and specialization on patient outcome, which showed volume of surgical experience to be an important indicator of good outcomes.

In Foot and Ankle specifically, better union outcomes occur in surgeons with more than 24 cases of ankle fractures per year compared with less than 24 ([redacted]). Better wound outcomes if more than 7 of the same procedures per year are performed ([redacted] and sophisticated and technical surgeries such as ankle replacement (and fusions) require 30 cases to achieve competency - a number that would be hard for any individual "podiatric surgeon" to achieve given the numbers quoted below [redacted]

The numbers of cases performed by Podiatric Surgeons (from their own data) precludes them from obtaining and maintaining core competencies [redacted] The combined activity of the entire cohort of "Podiatric Surgeons" would not allow even one of them to have the surgical experience to safely undertake an ankle fusion, but they are permitted to do so by the PBA, and the use of the item number 50118 indicates that they are occasionally performing these procedures.

A number of peer-reviewed high quality articles report lower complication rates and higher success rates of surgery when comparing comparable surgeries performed by orthopaedic surgeons and podiatric surgeons in the United States including, "Surgeon Type and Outcomes after inpatient Ankle Arthrodesis" Chan et al JBJS 2019 Jan 16;101(2):127-135, and " Lower Complication Rate Following Ankle Fracture Fixation by Orthopaedic Surgeons versus Podiatrists" Chan et al Journal American Acad Orth Surg August 15, 2019 vol 27, no.16. This in spite of a standardised and comparatively well run podiatric surgery training programme in that country. In this country where the training pathways are so disparate, a comparison of orthopaedic surgeons and "podiatric surgeons" would not bear mentioning.

In addition, there is recognition of this inferior performance being transmitted to trainees – "Podiatric Resident Performance on a basic competency Examination in Musculoskeletal Medicine" Creech et al Journal of Foot and Ankle Surgery 55 (2016) 45-48.

[redacted]

Inadequate audits used as claims of safety and good outcomes

"Podiatric Surgeons" have referred to an audit which they conduct, as a method of verifying that they are ensuring good quality control and using this as evidence that they have good outcomes with their patients.

We have reviewed the available data and point out that they do not have an adequate follow up period.

These audits are vastly inferior compared to the compulsory audits a practising orthopaedic surgeon must complete yearly to meet continuing professional development requirements. Of great concern, the duration of the podiatric surgical audit is only 30 days.

"Podiatric Surgeons" state they are qualified to perform osteotomies, internal fixation with screws, fusions of joints and deformity correction, however, these surgeries require up to three months of immobilisation and 12 months of aftercare for a determination of relative success. As such, an audit of 30 days does not reflect anything meaningful regarding the outcome of treatment of the patient. At best, it can be said that this is an audit of early acute infections. Most major complications such as non-union or malunion, inappropriate metalware position, delayed wound infection and progression of arthritis would be missed during a 30-day audit ([redacted]).

In addition, as a proportion of "Podiatric Surgeons" do not have prescribing endorsement, and prescribing endorsement is not required to be registered as a podiatric surgeon. As such, many patients treated by an operating podiatrist with a post-operative infection would need to see a medical doctor for antibiotic treatment, most likely their General Practitioner or local Emergency Department. In addition to creating an unnecessary burden of care, this would result in these post-operative infections not being including in a podiatric surgery audit as the complication is managed by a medical doctor who can actually treat the patient with a prescription for antibiotics and admission to hospital for intravenous antibiotics if required.

For the above reasons, the effectiveness of surgical intervention cannot be determined with the 30-day audit period reported by podiatric surgery. Standard orthopaedic audits, both in the public and private systems, are of at least six-month duration and are usually compared to previous reporting periods.

The mere fact that these podiatric surgery audits are relied upon by the PBA as part of a process of continuing quality assessment and monitoring, indicates a lack of understanding of bone and joint surgery, and the complications that can be associated with invasive surgical procedures. We are concerned that many complications may have been missed by a 30-day reporting period by a "podiatric surgeon", reflecting poor regulatory process.

In the work by Bennett ([redacted]), he describes his audit of the outcomes of Podiatric Surgery performed by members of the ACPS. This was part of [redacted], and so considerable efforts were made to follow up patients. It is astonishing to read the "Results Section" which reports a 20% loss to follow up at 30 days post procedure in only a small patient cohort (n=142). This study's conclusions are unreliable as the outcomes in patients lost to follow up have been shown in studies to be poorer than the cohort followed. It was reported that 85 of the 142 patients in the cohort would have the operation again, but this is only a 60% satisfactory outcome. Any similar outcome in orthopaedic surgery would be met with widespread concern from peers and an immediate review of surgical technique and close monitoring of that surgeon's future procedures and patient selection. It is unclear why this audit was an acceptable reflection of podiatric surgery outcomes to the Podiatry Board of the time ([redacted]).

Overall, we believe that the Podiatry Board, which consists of podiatrists, "Podiatric Surgeons" and general community members, seems to lack an understanding of what constitutes an appropriate audit period for standard surgical procedures. This lack of understanding and insight has resulted in years of countless notifications and poor outcomes, and we are

concerned overall, that the lack of AMC-accredited training standards has resulted in a cumulation of patient complications that represents substandard, unethical and at times, simply dangerous practice.

We believe the current high notification rate for "podiatric surgeons" reflects a lack of operative exposure and inflation and exaggeration of operative experience to meet podiatric surgical training requirements at the expense of the public who are then treated by an inadequately trained "surgeon".

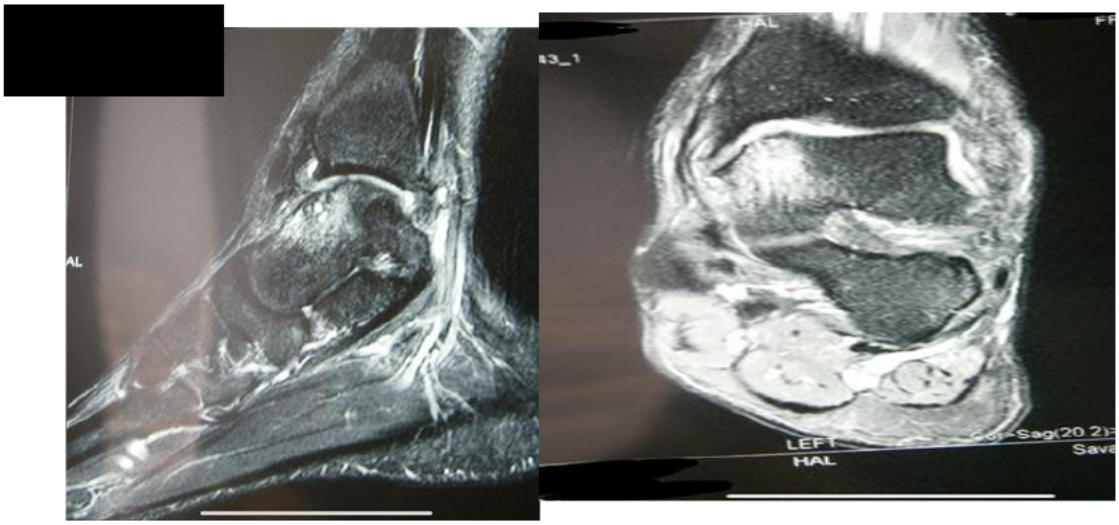
8. Do you have any concerns about the approach used by Ahpra and the Podiatry Board to manage notifications about podiatric surgeons, including the risk assessment process?

A member of the AOFAS relates their experience in making a mandatory notification regarding a "Podiatric Surgeon": *"On the first occasion, I advised the PBA that a patient I had seen had had an operation performed by a "Podiatric Surgeon" that had never been recorded in the literature. It was not the operation that the patient had consented to, and the use of this poorly thought out, ill executed, experimental procedure had inflicted irreparable damage to the patient's ankle which was now developing arthritis at the age of 20. Moreover, the "Podiatric Surgeon" concerned was under supervision by the PBA at the time, as part of his practice restrictions place on him by QCAT.*

After formally advising the 2012 PBA of this event and providing the Mandatory notification that I am required by the Legislation to lodge, I expected to have to provide the Board with images and a formal report outlining the events, the injury and imaging to justify the notification and to allow the Board to investigate the matter. Without any discussion with me or contacting me to ask to review the medical information and imaging, the PBA summarily dismissed my complaint discussing it with the "Podiatric Surgeon", but not with me, and not investigating the appropriate issues. I found that to be an extremely inadequate response to my mandatory notification and a failure of the Duty of Care of the PBA.

I thus made a complaint to AHPRA regarding this situation, and their response was to refer my complaint about the conduct of the PBA back to the PBA to adjudicate! AHPRA did not conduct any investigation as to whether an appropriate response had been taken or why the PBA did not contact me for information to assess if an investigation was warranted".

By declining to review the retained documents, the Board could exempt itself from examining the images which proved the damage to this patient"



We are concerned that there was no investigation, call for medical records or further discussion with the patient or orthopaedic surgeon who made this complaint. When concern was expressed about the regulatory process to the peak regulatory body in Australia, the complaint was referred back to the very same Board whose actions were the subject of the complaints process in the first place. The risk assessment process therefore does not include independent practitioners who may be able to offer insight into the severity of the complaint and there is no input from medically trained doctors who subsequently manage these complications. ([redacted] Names redacted as the issue is the process, not the specific Podiatric Surgeon**)**

9. Do you have any concerns about advertising by podiatric surgeons and the management of advertising offences?

There is widespread concern from medical practitioners regarding the supervision of "Podiatric Surgeons" and their adherence to the advertising legislation for all health practitioners. AHPRA has received multiple notifications about concerns that "Podiatric Surgeons" have misled the public by exaggerating and embellishing their educational qualifications through the dissemination of false and inaccurate information on misleading websites.

These websites have been reviewed and claims investigated. "Podiatric Surgeon" [redacted] states on his website that he has 'completed a post-graduate program in podiatric medicine at the [redacted] …' (see screenshot of [redacted]'s website below).

[redacted]

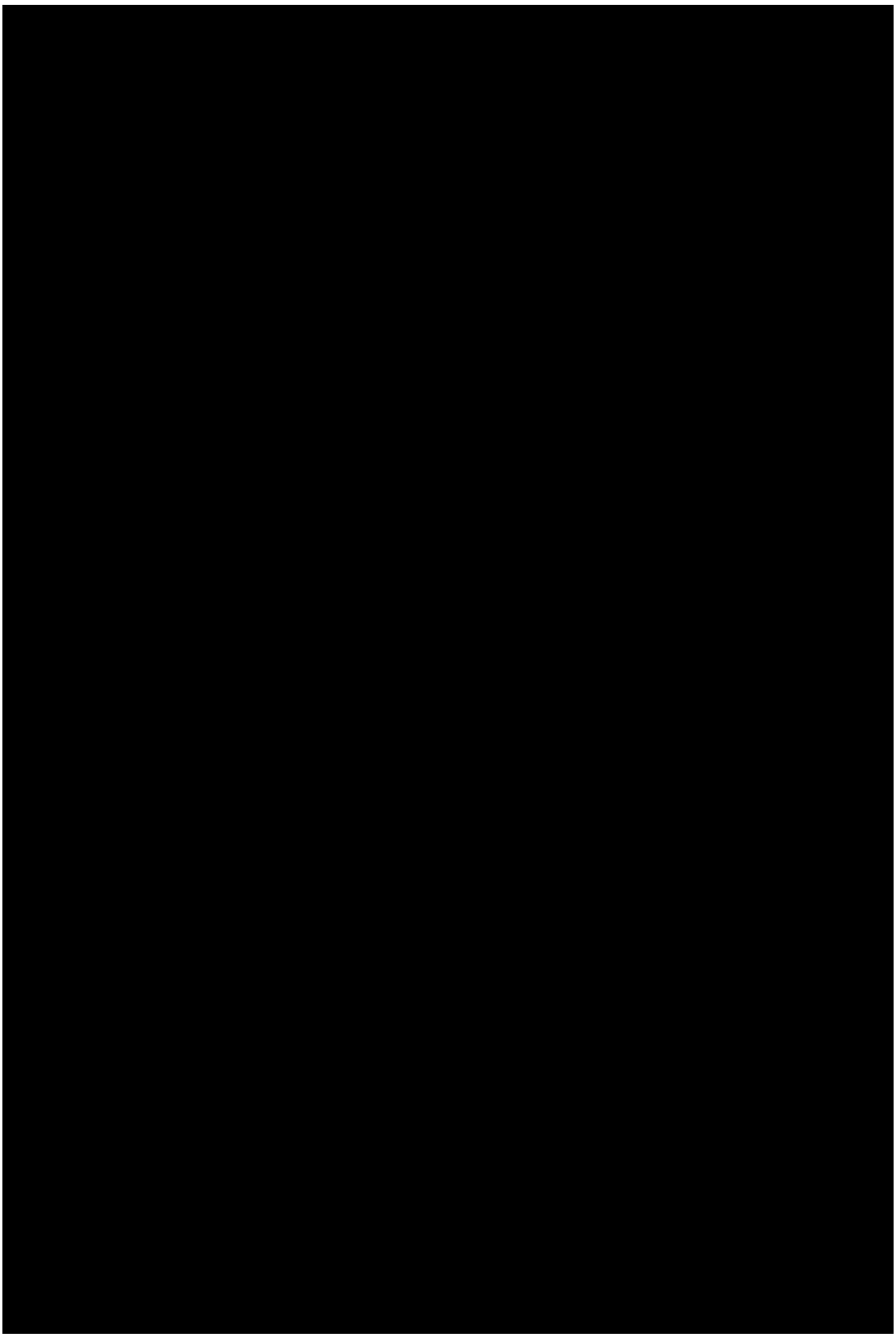
However, this would have been contrary to the [redacted] ([redacted]) own entry requirements. A letter to the [redacted] shows that there is no record of [redacted] ever attending the institution (see below): ([redacted])

This kind of advertising is misleading at best, and a breach of national law at worst.

A review of podiatric surgical registrar [redacted] current website [redacted] states that he practices 'Foot and Ankle Medicine'. His qualifications are listed as a member of the Australian College of Podiatric Surgeons. [redacted] is a current podiatric surgical trainee under the ACPS program.

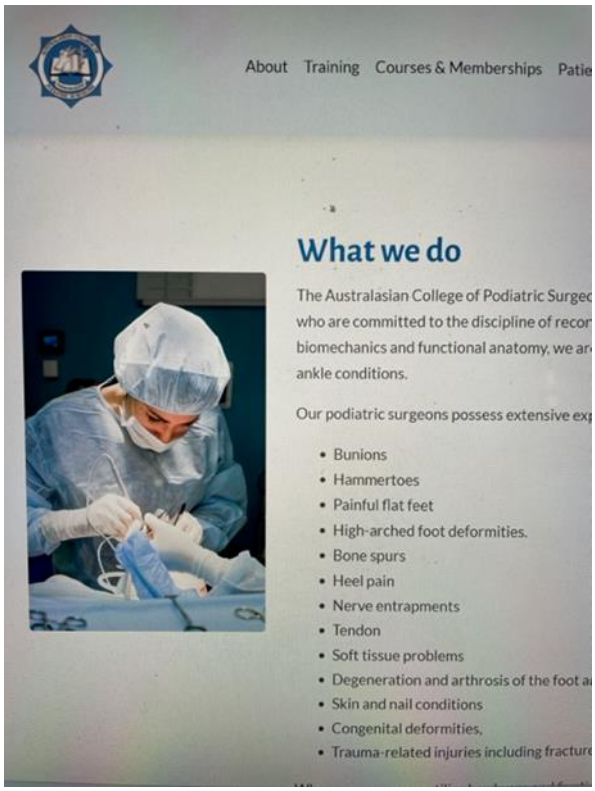
His website gives the impression he is a medically trained doctor by using the term 'foot and ankle medicine' and using the Caduceus (snake insignia commonly associated with medical practitioners, including the Australian Medical Association) and does not actually state he is a podiatrist. Furthermore, correspondence form this individual has the phrase 'foot and ankle medicine' as part of his signature and letterhead, when communicating to other health practitioners.

Last but not least, [redacted]' website states that his qualifications include 'specialist register and medical board registration" which is deceptive, false, and misleading.



These are just a small sample of many misleading and deceptive advertising and self-promotion strategies employed by associates of ACPS and suggest that the training program is not teaching appropriate standards of ethical conduct, professionalism, and advertising. The current training program does not appear to provide adequate education and training, as there is no specialty of 'foot and ankle medicine' and [redacted] is misleading the public with this self-appointed claim.

The ACPS's own website advertises procedures performed by a "Podiatric Surgeon", including painful flat feet, high arched foot deformities and arthrosis of the foot and ankle despite less than 6% of procedures performed during training involving these conditions according to the only available audits, as has been referenced earlier in this submission.

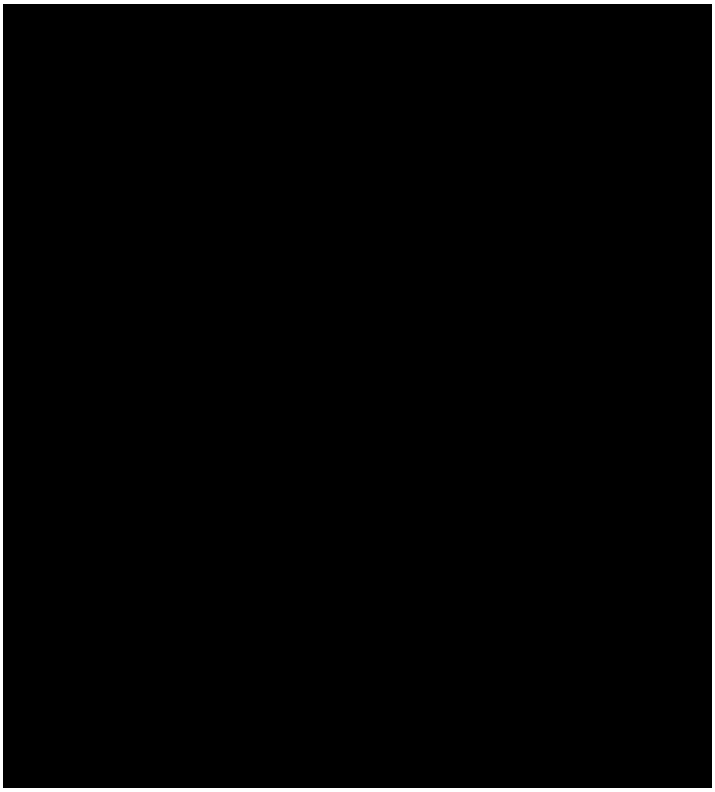


Podiatric surgeon, [redacted] authors a YouTube channel. In 2021, he posted a video demonstrating an attempt to drain synovial fluid from the knee (see screenshot below).

This video was met with outrage and incredulity from the medical community, and, it would be fair to say, extreme disappointment that something like this could happen in Australia. First and foremost, the patient clearly has pre-patellar bursitis which is a localised infection requiring simple antibiotic treatment and does not require an aspirate. Secondly, [redacted] does not have prescribing endorsement (nor should any podiatrist with prescribing endorsement use their endorsement to treat infections they are not trained in managing). Thirdly, the knee aspirate was performed incorrectly and had potential to seed infected bursal tissue into the knee and cause septic arthritis – infection of the knee joint itself. After multiple complaints, this video was eventually removed, but [redacted] continues to use his YouTube

channel for self promotion. We also question whether his patients, including paediatric patients, have provided formal consent to appear in his videos.

The lack of regulatory process has allowed [redacted] to continue to post videos despite demonstrating he has acted well out of his scope of practice in a public forum. This clearly shows lack of insight, poor judgement and also potential for serious patient harm. The lack of long-term repercussions for [redacted] has been concerning, as he continues to practice as a “Podiatric Surgeon” and use his YouTube channel to promote his practice.



10. Do you have any further comments or suggestions relevant to Ahpra’s and the Podiatry Board’s regulation of podiatric surgeons?

It is acknowledged that many of these are legacy problems that predate the current Podiatry Board and indeed the creation of AHPRA but a change in the regulatory framework is required to mitigate harm to the Australian public as evidenced by the disproportionately higher rate of notifications of podiatric surgeons compared to general podiatrists and the large number of podiatric surgeons who currently have restrictions placed on their practice by AHPRA.

Australian podiatric surgery training does not conform to defined international or AMC standards and as such should not be supported by the Podiatry Board or AHPRA until such defined standards are attained.

If and when, podiatric surgery training programs have reached AMC or CPME standards then only practitioners who have completed these new benchmarked training programs should be able to practise podiatric surgery. To maintain the integrity of the regulatory system, practitioners currently undertaking podiatric

surgery should only undertake clinical activities for which their training is accredited, that of a general podiatrist.

I am happy for this submission to be published under my name.

Dr Peter Stavrou

President, Australian Orthopaedic Foot and Ankle Society

Knee + Foot + Ankle
SURGEON

5/12/2023

Professor Ron Paterson
Independent reviewer
podiatricsurgeryreview@ahpra.gov.au

Dear Professor Paterson,

Re: Errors in submission to Independent review of the regulation of podiatric surgery

I write to you on behalf of the Australian Orthopaedic Foot and Ankle Society (AOFAS) to inform you of two errors in our submission to your review received on 16/11/2023.

I the time between the drafting process and final submission, there were changes to the registration status of two "podiatric surgeons". At the time of final submission [redacted] and [redacted] did not have any restrictions on their practice. I apologise unreservedly to the Reviewer and Drs [redacted] and [redacted] for this error. I thus, wish to amend the submission in two places.

The answer to Question 3, page 10, paragraph 2 should be amended to:

We are aware that there is a high number of "podiatric surgeons" who have restrictions placed on their practice. A review of the AHPRA register of practitioners has demonstrated that three out of 32 podiatric surgeons who are fellows of the ACPS currently have their practice restricted. Currently, 9.3% of "Podiatric Surgeons" who are active fellows of the ACPS, the very organisation that states on their website that its primary objective "is to advance knowledge in podiatric surgery and uphold the highest standards of foot and ankle care provided by podiatric surgeons to patients and the community" are under supervised and/or restricted practice despite being granted their fellowship in podiatric surgery. This further suggests in concrete terms, that "Podiatric Surgeons" in Australia are not suitably trained and qualified, and are not currently practicing in a safe, competent and ethical manner.

The answer to Question 7, page 14, paragraph 1 should be amended to:

A review of the AHPRA register of practitioners has demonstrated that 3 out of 32 podiatric surgeons who are fellows of the ACPS currently have their practice restricted. Therefore, at time of writing, 9.3% of podiatric surgeons who are active fellows of the ACPS, the very organisation that states on their website that its primary objective "is to advance knowledge in podiatric surgery and uphold the highest standards of foot and ankle care provided by podiatric surgeons to patients and the community" are under supervised and/or restricted practice despite

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being granted their fellowship in podiatric surgery. There are therefore glaring inadequacies in the current podiatric surgical training program and the general public deserve to receive treatment by a practitioner whose training does not determine that 9.3% of its graduates need to be supervised or have their practice restricted after their 'training'.

I would also like to inform you of another error regarding prescribing endorsement. While our submission indicated that five "podiatric surgeons" were practising without the necessary prescriber endorsement, the correct number is actually ten. I would like to make a further amendment to the submission.

The answer to Question 4, page 10 final paragraph, should be amended to:

Prescribing endorsement for "podiatric surgery" is now compulsory, but a review of AHPRA registration demonstrates that at least 10 "podiatric surgeons" registered with ACPS continue to practice without prescribing endorsement. We question how these practitioners are prescribing pain relief for their patients, or antibiotics in the setting of post-operative infection. AHPRA continues to support the registration of these "podiatric surgeons" who do not have prescribing endorsement despite contradicting their own standards of training and practice.

I apologise for these errors and wish to correct them prior to any public release of the document.

Yours sincerely,

[redacted]

DR PETER STAVROU
MBBS FRACS FAOrthA
Orthopaedic Surgeon
President Australian Orthopaedic Foot and Ankle Society